September 8, 2008

Secretary John M. Colmers, Chair
Governor's Task Force on Health Care Access and Reimbursement
Maryland Department of Health and Mental Hygiene
201 West Preston Street
Baltimore, MD 21201-2399

Dear Secretary Colmers and Members of the Task Force,

I am a practicing clinical anesthesiologist in a large group practice where I also chair its Quality Improvement committee. I am and have been involved in medical staff leadership and legislative initiatives and have served on a prior governor's task force.

Having reviewed the agenda, minutes, and recommendations of the task force to date, I would like to suggest to the members that prior to making final recommendations an opinion from a 'ground troop' might serve as a reality check. I believe that for all the in-depth analyses of root causes of physician shortage/maldistribution there are some simple, immediate remedies that may help improve access while the larger issues are being debated and addressed.

I volunteer medical services in Africa, S America, and Asia, and through my personal experience have found that there are some simple core principles that affect the delivery of healthcare all over the world that perhaps might be applicable to the state of Maryland as well. The Task Force has correctly identified that below market pay and high cost of living affect how doctors decide where they will practice. This is just as true in rural Kenya or Ecuador as it is here.

When we attempt to recruit new doctors to our practice the three questions that we must always answer are: 1) What will I make now and in the foreseeable future?, 2) How often am I on call?, and 3) What is my professional/work environment like?. Very simply, I believe that all clinical doctors like to work in environments where they believe they can:

1) **deliver the highest quality care for their patients**,
2) **earn a decent living, and**
3) **maintain reasonable control over their professional and personal lives**.

It appears to me that the Task Force, having identified fairly straight forward problems, has not addressed equally straight forward solutions: Incentive medical care in shortage areas with improved income and lower overhead, and reduce inefficient and unnecessary paperwork. Any reimbursement plan that does not address these basic needs will in my opinion be a paperwork exercise at best, and will exacerbate them at worst. The recommendations to date fall short in the fundamentals.

For example, ***linking reimbursement to Medicare and expanding of Medicaid without providing for increased payment from private insurers will have the opposite of its intended effect in many specialties. That is, this will lower net reimbursement and increase practice overhead***. This is not a conjecture, it is a fact. When assessing whether we can accept an RFP to staff a hospital or ASC without a subsidy the percentage of Medicare and Medicaid

are determining factors, since they lower average compensation to levels that prevent recruitment and retention of physicians. Medicare and Medicaid reimbursement are not determined by any competitive market and hence require subsidization by private payors or hospitals when private insurance reimbursement does not keep pace with the true market.

I would like to suggest that the Task Force consider making the following recommendations, followed by whatever long term corrective actions it feels will be needed to steer health care to what it believes is a more rational course. These are based on existing reimbursement models and use basic, proven incentives that will likely result in immediate improvements in physician maldistribution.

Recommendation 1): Mandate either payor-based fee schedule *floors* that reimburse Maryland physicians at the higher of national or regional averages for their specialty, or provide collective bargaining "safe harbors" for physicians, or both. Rates must reflect un- and under- compensated care load.

Rationale: Maryland will be competitive with other states on physician income. Shifts costs from provider hospitals and physicians back to business entities profiting from current underpayment. Provides incentive for payors to increase claims processing efficiency and reduce waste. Provides opportunities for more efficient insurance carriers to enter the market. No effect on state budget. Provides for long term stability in contrast to loan forgiveness programs.

Recommendation 2): Absorb malpractice premiums in what the state identifies as critical shortage locations.

Rationale: Practice overhead lower, furthering financial incentive in shortage areas. Costs are already being borne by a state subsidy, but will now be directed and specialty-specific. Legislators will be incentivized to address malpractice costs as a state budget item.

Recommendation 3): Mandate a transition to Electronic Health Records by payors and medical facilities (hospitals and ASC's) over a reasonable, specified time.

Rationale: Evidence-based medical decision making, efficiency in claims processing, and reimbursement data will all be available to regulators and clinical decision-makers. A government mandate will be necessary to force investment by and cooperation between stakeholders. Will jumpstart individual practice incorporation of EHR. Will provide Maryland a platform for continuing its Medicare exemption based on easily accessible data.

We look forward to assisting the Task Force fulfill its mission in averting Maryland's impending medical crisis and will be available to any of the Task Force members who would like to hear our recommendations or concerns.

Thank you for your consideration.

William Chester MD